Form 2 (version 03/27/2001)

Suspected Botulism Clinical Outcome Report

PLEASE PLACE ON FRONT OF PATIENT CHART:

To be filled out and faxed/mailed to CDC at The time Patient is Discharged from hospital.

Send to: **Centers for Disease Control and Prevention**
Foodborne and Diarrheal Disease Branch
Mail Stop A 38
1600 Clifton Rd.
Atlanta, GA 30033
Phone: 404-639-2206

OR **Fax to: 404-639-2205**

THANK YOU.

Person filling out Form: _____ Date: _____/_____/_____ ***(mm/dd/yyyy)***
Patient's Name: _____
Hospital: _____ State: _____
Attending Physician: _____ Phone: _____ Fax: _____

Clinical Outcome ***(Please circle the appropriate answer)***

1. Was the diagnosis of botulism confirmed? YES NO DK
   If no:
   A. What was the final diagnosis? _____
2. Did patient require mechanical ventilation? YES NO DK
   If yes:
   A. How many days was patient on a ventilator? _____ days
3. Did the patient require a tracheostomy? YES NO DK
   If yes:
   A. When was the tracheostomy done? ____/____ /_____ ***(mm/dd/yyyy)***
4. Did the patient develop pneumonia? YES NO DK
5. How many days was patient hospitalized? _____ days
6. How many days was patient in intensive care? _____ days
7. Describe the clinical course of paralysis after administration of the antitoxin
   _____
   _____
8. Was there residual paralysis? YES NO DK
9. Did the patient survive? YES NO DK
   If yes:
   A. Was patient discharged from hospital to ***(circle appropriate answer)***:
      Home Nursing home Rehabilitation facility Other
      Specify other _____
   B. Did the patient have residual disability on discharge? YES NO DK
      Explain _____
   If no:
   A. What was the cause of death? _____

Thank you. Please return to CDC at the contact information above.